Psychiatric Aspects of Sexual Abuse Involving Persons With Developmental Disabilities

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Objective: To consider psychiatric issues that relate to the prevention and management of sexual abuse involving persons with developmental disabilities as either abusers or victims.

Method: Seven case descriptions illustrate the clinical challenges raised by allegations of sexual abuse.

Results: Mental disorders and communication problems often coexist with the cognitive impairment that is primary in developmental disabilities. Pedophilic behaviour prompts allegations of abuse, and posttraumatic stress disorder often follows abuse. Difficulties communicating with others may preclude the detection of abuse or normal legal proceedings once an allegation is made.

Conclusions: Psychiatric expertise applied both directly and indirectly through others is relevant in the prevention of sexual abuse and the management of those with developmental disabilities who are abusers or abused.


Key Words: developmental disability, mental retardation, sexual abuse

Concerns about sexual abuse involving persons with developmental disabilities appear to have been overshadowed in the 1970s and 1980s by efforts to establish their basic human rights (1,2). Although these concerns are now receiving increased attention, Cooke notes “disappointingly little” published material on the topic by psychiatrists but, at the same time, “growing awareness of the contributions of abuse to the development of psychopathology and the need for detailed and concrete evaluations to enable the appropriate therapeutic interventions to occur” (2).

Of 8 studies concerned with sexual abuse involving persons with developmental disabilities (1), only the Kent study in England by Turk and Brown was designed to generate an incidence figure (that is, 0.0164 allegations per 1000 general population per annum) (3). Applying this figure to the current Canadian population suggests that nearly 500 allegations yearly would be documented by social agencies serving adults with developmental disabilities, were there an appropriate reporting system in place.

This paper reviews 7 cases referred to a tertiary health centre. They have been selected to illustrate pedophilic behaviour (cases 1 and 2), posttraumatic stress disorder (PTSD) (cases 3 and 4) and the challenges involved in investigating allegations of abuse (cases 5, 6, and 7). “Peer abuse,” that is, abuse of one agency client by another (4), is not represented in this study.

Case 1 – A

A is a 46-year-old man with a moderate degree of intellectual impairment. He maintains his own apartment and volunteers as a helper in the barbershop of an nearby institution. He has no close friends and looks forward to periodic visits from his community social worker. Two or 3 times each year, he visits his elderly parents who live in another town in the area. Although A gets along reasonably well with his mother and brother, he has always had problems relating to his father, whom he describes as never having been able to accept A’s disability.

From 8 to 20 years of age, A resided in the institution where he volunteers. He was admitted for special education and training because of tantrums and rage attacks that have now disappeared. When A first left the institution, he lived near his parents, but after 6 years he moved to his present location to be further from his father and to get professional help from a psychologist at the institution.

A was referred to the psychiatry clinic because of “behaviour problems,” including public displays of immature behaviour, vulgar sexual comments to children, and verbal abuse of his father. Although he has been warned by the police about his comments to children, the citizens of his town are surprisingly tolerant of his attention-seeking behaviour. Subjectively, A reports that he is fearful (for example, he never leaves his apartment after dark), depressed about lack of respect from his father, and somewhat ambivalent about childhood homosexual experiences in the institution. The latter form the content of his masturbatory fantasies.

Discussion

The sexual offences committed by persons with developmental disabilities are less violent than those committed by others (5). Turk and Brown list “serious teasing or innuendo” with “looking, photography, indecent exposure, harassment and pornography” as examples of “noncontact” abuse (3).
The absence of any formal response to A’s vulgar comments to children beyond warnings from the police appears to reflect their perception that this is nuisance behaviour and, in fact, often provoked by latency-age males who tease A quite frequently. A recognizes that his language is socially unacceptable, does his best to suppress it, and may be helped somewhat by fluoxetine, reducing the intensity of the “moody spells” in which he is most likely to react. Reid suggests that: “In most people with learning disability, and in many grown up childhood psychotics, problems of sexual behaviour are more correctly seen as developmental phenomena and socially inappropriate, rather than as driven by deviant or aberrant sexuality” (6). A has never shown an interest in a mature sexual relationship and appears to be arrested at a primitive stage of psychosexual development.

Case 2 – B
B, now 44 years old, has a mild intellectual impairment and is able to communicate well. Although his general health is good, his life is complicated by an episodic mood disorder and pedophilia. Born to a 14-year-old single mother who was unable to assume parental responsibility, B was raised by a foster family until the foster mother’s untimely death when he was 8 years old. B has been frustrated by his lack of success in trying to locate his biological mother and by indifference to his welfare by other members of the foster family. Depressive episodes of several weeks’ duration often follow insults or other interpersonal conflicts. For example, he became moody, irritable, and aggressive; the mother of a woman B wanted to marry, having heard about B’s pedophilic tendencies, saw to it that the relationship would end, so B stole money from a friend. Although B has never been charged with a pedophilic offence, he seeks out and stares intently at children at play, thereby provoking major concerns about risk in the agency that provides his residential, vocational, and leisure time support services. At first reluctant to discuss his sexual interest in children, B was more forthcoming after penile plethysmography revealed clear evidence of erotic responses to child stimuli. B associates his preoccupation with children to memories of mutual masturbation and anal intercourse with his peer group in an institution to which he moved after his foster mother’s death.

B’s treatment program has involved intervals when he received thioridazine, fluoxetine, and cyproterone acetate. He has had inpatient care in a regional psychiatric hospital on 2 different occasions. Counselling sessions have focused on his sexual and mood problems as well as on the search for his biological mother. B is never left unsupervised with children, but a new challenge is his goal to live in a cooperatively maintained apartment (where many hours each week are unsupervised) rather than in a group or family home, as has been the residential arrangement since he left the institution at age 21 years.

Discussion
B’s pedophilia exemplifies sexually deviant behaviour, in contrast to sexually inappropriate behaviour in persons with developmental disabilities that arises “from living in a system in which appropriate sexual knowledge and relationships are not supported” (7). The latter, referred to as “counterfeit deviance” by these authors, is illustrated in their report of a 46-year-old moderately retarded man whose phallometric responses were “normal for an adult heterosexual male” and whose pedophilic behaviour was successfully resolved, not by treatment, but by support in establishing appropriate adult–adult relationships. B’s treatment is similar to that provided for nonintellectually impaired pedophiles (8). B was able to provide informed consent, and agency staff are aware of the use of a libido-suppressing drug (10). If there is a consensus that he should be given an opportunity to live in a co-op apartment, new approaches to risk management including self-monitoring (11) and “invisible supervision” (12) will be required. Such approaches must be seen as innovative and, as yet, unproven, although very much in keeping with the agency’s dual responsibility to B and to young children in the area where he may reside.

Case 3 – C
C is 36 years old, has a mild intellectual impairment, and, apart from having a shy, introverted demeanour, communicates normally. C is devoted to her husband and her 9-year-old son, both of whom are described as intellectually limited. One of 17 siblings, C was 15 years old when her mother died. After 2 years in a foster home, she moved to her own apartment, left school, and worked in a shelter workshop until she married. C is troubled by severe arteriosclerotic heart disease. She had a coronary bypass procedure and takes medication for hypertension and hypercholesterolemia. Her medical history includes migraine headaches, irritable bowel syndrome, and a partial hysterectomy.

C says her psychiatric problems commenced suddenly 5 years ago when she was watching a romantic TV program. Her mind went blank and then was flooded by memories of sexual abuse (forced intercourse and sodomy, forced to preform fellatio) by her father and a brother over several years. Since that time, she has vivid flashbacks of the abuse, often triggered by seeing family pictures. She has depressive symptoms including insomnia, thoughts that her heart disease represents divine punishment for not confronting her late father about his abusive behaviour, weeping,
and anergy, and she has been hospitalized twice for drug overdoses. She experiences nightmares and, on one occasion, during waking hours, was convinced her husband was her father.

Presently, approximately 1 year after first referral, C is better able to cope. Counselling sessions have focused on reassuring C that she is not crazy and informing her about the nature of PTSD. Treatment with paroxetine has relieved most of her depressive symptoms.

Discussion

C’s symptoms and the background of sexual abuse are in keeping with Ryan’s account of PTSD in persons with developmental disabilities (13). Ryan’s study of 310 consecutive referrals to a Colorado clinic for persons with developmental disability identified 51 persons who met the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) criteria for PTSD. The study revealed that many had previously been diagnosed with schizophrenia, that many cases had a medical illness “which would be expected to exacerbate psychiatric symptoms,” and that most who were provided with a comprehensive treatment protocol improved. The protocol for the patient recommends judiciously using medications (including fluoxetine, carbamazepine, and naltrexone), identifying and treating medical problems, minimizing iatrogenic complications (especially the use of neuroleptic drugs), attending psychotherapy, and minimizing exposure to “dissociative triggers” and recommends practical education on PTSD for agency staff. Fresco, Philbin, and Peters describe the use of support groups for women who are developmentally disabled and have experienced sexual abuse (14); personality measures did not reveal significant improvement until after 2 years’ continuing participation in the group. Earlier, agency staff reported more assertiveness, self-confidence, and “acceptance of their sexuality.” It seems likely that a comprehensive treatment plan such as advocated by Ryan (13) is preferable to reliance on psychotherapy alone.

Case 4 – Siblings M and F

M, male, age 26 years and severely intellectually impaired, and F, age 25 years and moderately intellectually impaired, are brother and sister. He lives in a group home under 24-hour supervision, and she lives in an apartment and receives periodic visits from her social worker.

Their father, an unemployed labourer who has a history of excessive alcohol intake, is said to have a mild intellectual impairment. Their mother, of borderline intelligence, like M and F was physically abused by their father, and the parents have been separated at times. M and F were made wards of the Children’s Aid Society in their early teens because of this abuse; presently, M sees the parents in the company of group-home staff every 3 months, and F refuses altogether to see them.

M’s behaviour has been a major concern for many years. Described as “hyperactive” as a preschooler, his problems now include insomnia, aggression, extreme mood lability, and excessive masturbation; he is sexually aroused by clothes dryers. His language skills are poorly developed. He rarely answers a question put to him and engages in echolalia or utters various threats (often mentioning his father by name).

F’s behaviour is described by her social worker as “erratic” and includes pacing, giddiness, poor concentration, rudeness, invading other people’s personal space, and inappropriate touching and hugging. F communicates reasonably well and describes nightmares, fear (of meeting her parents on the street), and extreme uneasiness (if witnessing displays of affection). Although she has denied being sexually abused by her father, she has flashbacks in which she visualizes him forcing her mother to have intercourse in front of the children, and she has a recurrent dream that she is pregnant by her father.

Discussion

This case illustrates the association of physical and sexual abuse (probably noncontact abuse) and what appears to be PTSD in individuals who, in contrast to case C, are somewhat less able to communicate their distress to others. M’s frequent reference to his father and F’s visualization of her father sexually intimidating their mother appear to represent “flashbacks.” Although M was never regarded as psychotic, F was seen as suffering from bipolar disorder and was receiving high-dose haloperidol treatment when first referred. Neither M nor F has shown major improvement on psychotropic medications, although fluvoxamine appears to have relieved some of the anxiety and restlessness that characterizes their behaviour. Limiting or avoiding parental contact, a trigger of behavioural regression, is obviously important, although contact with each other is much less likely to be followed by difficulties. Razza outlines some of the important aspects of PTSD in persons with mental retardation, including misdiagnosis as psychotic, the role of frightening dreams, the particular types of events that may be traumatic (that is, perhaps not traumatic to persons without mental retardation), and a “substantial time delay” between the experience of the trauma and display of symptoms (15).

Case 5 – D

D is a 30-year-old woman with Down syndrome. She was referred by her social worker for assessment relating to D’s allegation that her father forced her to have vaginal and anal intercourse 6 months earlier.
D was raised in a large, supportive rural family. Her mother died when D was 28 years old. Shortly thereafter, she left home suddenly to live in a common-law relationship with a 54-year-old man whom she had met in the shelter workshop. Since then, D has paid little attention to her hygiene and nutrition. For the first time in her life she has stolen something: as she left home after a Boxing Day visit (the day of the alleged incidents involving her father), she attempted to hide an expensive camera in her purse for the purposes of stealing it. Since the allegation about her father, her siblings, although still concerned about her, refuse to interact with D. A brother, who serves as their spokesman, reports there is “no way” their father would abuse D, and he suspects that the common-law husband coached her to tell the story.

D was assessed as to her understanding of sexual matters and of the legal implications of her complaint; D’s distress at being distanced by her family was also noted. Although she uses “street language” to refer to sexual anatomy and relationships as portrayed in pictures, D has a basic understanding of the facts of life. In contrast, she has no understanding of the medical or legal procedures for investigating sexual abuse. She was unaware of the meaning of swearing an oath. She suggested that, if her father gave her $50.00, the matter would be resolved, although she adds that she never wants to visit him again. D revealed no evidence of PTSD.

Discussion

Psychiatrists are often asked to evaluate an individual’s testimonial capacity. The key components of testimonial capacity are “the capacity to understand the nature and purpose of an oath” and “the ability to distinguish fact from fiction, make observations, recollect and communicate the essence of his or her knowledge in the matter” (16). In D’s case, her moderate degree of intellectual impairment was associated with an inability to meet the first requirement and marginal ability in achieving the second.

A related issue in D’s case is her credibility. On balance, it seems very likely that her allegation is untrue and represents a feeble attempt to get money from her father. The court, not the psychiatrist assessing testimonial capacity, is to determine if a witness is to be believed.

Case 6 – E

E, now 11 years of age, has a moderate degree of intellectual impairment.

When E was 5 years old, his mother (accompanied to the clinic by E’s teacher) alleged to the pediatrician that E had been sexually abused by his uncle. E was avoiding contact with the uncle. There was no physical evidence of abuse. Investigation by the Children’s Aid Society could not confirm that abuse had occurred and raised major concerns about his mother’s ability to care for him.

E’s behaviour at school and at home was problematic. His language was full of sexually explicit content, he threatened to expose his genitals, and he asked his mother to perform fellatio on him. His mother was inconsistent in cooperating with assessment or treatment. Because the mother had mild intellectual impairment, a history of drug abuse, and possible bipolar disorder, the maternal grandmother was identified as E’s guardian. The grandmother denied the mother’s account that the uncle is a homosexual with a history of sexual involvement with children.

Recently, E was treated for a psychotic episode during which he was convinced that someone had entered the house at night. He climbed onto the roof of the house and was threatening to jump when the police were called to rescue him. Presently, he lives with the grandparents—his mother was arrested on a drug charge 3 years ago, and they are not in contact.

Discussion

Investigating allegations of sexual abuse of children is the responsibility of child welfare authorities. Such investigations can be strengthened by the use of systematic techniques such as genograms and ecomaps, so all relatives or other persons in the child’s environment are considered (17). Frequently, family physicians and pediatricians who provide primary medical care for the child will be consulted as part of the investigation. Since there is rarely a witness or physical evidence of abuse, significant changes in behaviour or school adjustment are of interest and might signify abuse. Unfortunately, “these patterns are not specific and only a minority of children who show these behaviours actually will have been abused” (18).

In E’s case, avoiding his uncle, reported only by his mother and not confirmed by the grandmother, is of dubious significance in the absence of other symptoms or signs. His preoccupation with more adult types of sexual behaviour reflected his mother’s failure to shield him from these topics until he was cognitively and emotionally mature enough to handle them.

Lumley and Miltenberger suggest that children with mental retardation should be taught to identify and report incidents of abuse by teaching them first the names of their “private parts” and then that abuse occurs “when someone tries to see or touch your private parts” (19).

Observations of disabled adults suggest that some are more vulnerable to abuse than others, implying an opportunity to remedy “specific behaviours” that increase an individual’s vulnerability (20).

Case 7 – G
G, age 22 years, has moderate intellectual impairment and cerebral palsy with both spastic and athetoid features. His ability to communicate is considerably hampered by the cerebral palsy, but those who know him well can facilitate an interview with a stranger.

G and his mother approached the clinic for advice on how to proceed with a police investigation and possibly a court action relating to G’s allegation of sexual abuse by an agency staff member. In particular, G’s mother was concerned that his testimony would not be believed and that, in the absence of witnesses and physical evidence, the outcome of a trial would be psychologically devastating for him.

About 1 month prior to his clinic visit, G told one of the staff at his day program that L, another staff member who had left the agency several years previously, had “sex up my bum.” Although G was uncertain as to dates and times, this incident would appear to have occurred several years previously. G could accurately describe L and said that some of the abuse occurred in L’s apartment, where he visited occasionally. As he did his best to answer questions about the matter, G’s involuntary movements increased dramatically, and his demeanour oscillated between weeping and angry statements about L—“I want him to go to jail for 10 years!”

G recognized accounts of recent current events and could accurately name several players on his favourite hockey team, but he was quite unable to describe the role of a lawyer or judge or the significance of an oath.

Discussion

Clare and Gudjonsson have identified a special vulnerability to give erroneous testimony during police interrogation of persons with mental retardation (21). This vulnerability is based on interrogative suggestibility (yielding to leading questions), confabulation (filling memory gaps with imaginary experiences that the person believes to be true), and acquiescence (answering questions affirmatively, regardless of their content).

G’s mother, the investigating police officer, and the psychiatrist were convinced as to the veracity of G’s allegations. However, G could not be seen as having appropriate testimonial capacity. His case illustrates the need for a system of investigating and reporting the suspected abuse of disabled adults such as already exists for children. In the Kent study, the offender was an agency staff member or volunteer in 14% of the cases (3).

Hollins and her colleagues have prepared a series of “Books Beyond Words” for disabled persons who need help communicating about abuse or serving as a witness (22–24). Stories relevant to these matters are told entirely through pictures, allowing each reader to have his or her own interpretation. Some individuals like G may find support in identifying with others who have been abused and, should there be a court action, can proceed with a better conceptualization of what they will encounter there.

Conclusions

These cases illustrate some of the challenges created by allegations of sexual abuse for teachers, the staff of agencies serving disabled persons, law enforcement officers, and psychiatrists. Figure 1 summarizes these challenges and identifies 3 categories of social impact that flow from particular impairments seen in those with developmental disabilities. It then identifies the professionals and agencies best equipped to minimize each impact. Although cognitive impairment is central to the definition of developmental disabilities, communication problems and various mental disorders are also prevalent. In terms of particular supports, special education ensures that difficulties learning about sexuality are addressed, agency staff and law enforcement officers ensure that sexual activities and distress are accurately communicated, and psychiatrists manage the particular disorders that predispose individuals to victim or offender status.

Figure 1. Minimizing the social impact of sexual abuse of and by persons with developmental disabilities

Beyond the clinical management of individuals with various disorders such as PTSD and pedophilia, psychiatrists can help in the broader context by promoting understanding of the psychosexual development of persons with developmental disabilities and by serving as consultants to colleagues in the education, social service, and law enforcement sectors.

Clinical Implications

- Pedophilic behaviour in persons with developmental disabilities may represent arrested psychosexual development or inadequate social training rather than a true paraphilia.
- The cognitive and communication impairments seen in persons with developmental disabilities can complicate the recognition of posttraumatic stress disorder following sexual abuse.
- Psychiatrists may be asked to evaluate the testimonial capacity of a person with a developmental disability who serves as a witness in a sexual abuse matter in court.
Limitations

- The magnitude of the sexual abuse problem is addressed only through application of the results of a British study to the Canadian population.
- The literature review is not comprehensive but focuses only on issues arising from the case descriptions.
- Peer abuse (sexual abuse of a person with a developmental disability by another person with a developmental disability) is not represented in the case descriptions.

References


Résumé

Objectif : Examiner les domaines de la psychiatrie qui ont trait à la prévention et au traitement de l’agression sexuelle impliquant des personnes qui souffrent de trouble du développement, à titre d’agresseur ou de victime.

Méthode : Sept descriptions de cas illustrent les défis cliniques soulevés par des allégations d’agression sexuelle.


Conclusions : L’expertise psychiatrique appliquée directement ou indirectement par d’autres est pertinente dans la prévention de l’agression sexuelle et le traitement des personnes souffrant de trouble du développement, qu’elles soient agresseurs ou victimes.